Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: Rehab 2112 P. O. Box 671342 Dallas, TX 75267-1342	MFDR Tracking #: M4-07-2417-01
	DWC Claim #:
	Injured Employee:
Respondent Name: ZURICH AMERICAN INSURANCE CO Box: #19	Date of Injury:
	Employer Name: WALGREEN CO
	Insurance Carrier #: A62180967200010121

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary (Table of Disputed Services): "Pre-auth is not required for CARF accredited programs. WH not paid a according to the DWC guidelines. Carrier did not respond to Request for Reconsideration for all DOS."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary (Table of Disputed Services):
Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Additional Amount Due
9-5-06, 9-7-06	62-855-003/no recon	97545-WH-CA ($30.72 x 2 days)	1, 2, 3	$61.44
9-5-06, 9-7-06	62-855-003/no recon	97546-WH-CA, 97546-WH-CA-59-52	1, 2, 3	$130.56
Total Due:				$192.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, Reimbursement Policies and Guidelines, and Division Rule 134.202 titled, Medical Fee Guideline effective August 1, 2003, sets out the reimbursement guidelines.

In a fax dated 04-03-07 the Requestor withdrew all dates of service except 9-5-06 and 9-7-06.

1. These services were denied by the Respondent with reason code "62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization," and "855-003-Service is denied for lack of proof of pre-authorization $0.00."

2. Per Rule 134.202(e)(5)(C)(ii) reimbursement shall be $64.00 per hour for CARF accredited programs. Per Rule 134.600 (p)(4) requestors who are CARF accredited do not require preauthorization.

3. A Legal and Compliance referral will be made for improper denial and inappropriate payment per Rule 134.202(e)(5)(C)(ii).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.301, §134.1, §134.202

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $192.00 plus accrued interest, due within 30 days of receipt of this Order.

Decision:

	Donna D. Auby	4-10-07
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. §413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision, that is the subject of the appeal, is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.